

PROVIDER CHANGE OF INFORMATION FORM

Provider Name

Provider Number(s) Effected By The Be Change

Old Service Address:

New or additional service Address:

Phone Number:

Old Pay-To Address:

New Pay-To Address:

Phone Number:

Old Mail-To Address:

New Mail-To Address:

Phone Number:

Old Billing Service Address:

New Billing Services Address:

Phone Number:

☐ **Change In Ownership Interest Or Corporate Status: (Requires New W-9)**

New Owners Names:

Addresses:

Date Of Change Of Ownership Interest:

Process By Which Change Occurred (i.e. merger, sale, gift, etc.):

New Corporate Status:

☐ **Change To Certification:**

Previous Condition:

Current Condition:

Date Of Change:

☐ **Notification Of Adverse Action To License:**

Action Taken:

By What Agency:

Date Action Effective:

☐ **Notification Of Bankruptcy Filing:**

Date Of Filing:

Type:

Attorney Name & Address:

Trustee Name & Address:

Authorized Signature:

Date:

(required to make change)

Print Name and Title:

* Please attach a separate piece of paper if necessary. Thank you for your cooperation.

* Please either fax change of information form to (401) 467-9581 or mail to the following within 35 days of the event triggering the reporting obligation:

EDS- Provider Enrollment Unit

PO Box 2010

Warwick, RI 02887-2010